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The Army Health Promotion Program

“Fit to Win” Individual Assessment

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SUMMARY of CHANGE

DA PAM 600-63-4

"Fit to Win"

Individual Assessment

Not applicable.

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The Army Health Promotion Program

“Fit to Win” Individual Assessment

By Order of the Secretary of the Army:

CARL E. VUONO
General, United States Army
Chief of Staff

Official:

R. L. DILWORTH
Brigadier General, United States Army
The Adjutant General

Army electronic publishing database. No content has been changed.

Summary. Not applicable.

Applicability. This guidance applies to installation commanders and members of installation/community health promotion councils. This includes but is not limited to: Director of Personnel and Community Activities (DPCA); Director of Logistics (DOL); Public Affairs Officer (PAO); Chief, Family Support Division (FSD); Chief, Community Operations Division (COD); Commander, Medical Treatment Facility (MTF); Director, Plans, Training, and Mobilization (DPTM); Civilian Personnel Officer (CPO); Chief, Community Mental Health Service (CMHS); Chief, Community Relations Division (CRD);

Alcohol and Drug Abuse Prevention Control Program (ADAPCP) Officer; Field Director, American Red Cross (ARC); Dietitian; Community Health Nurse (CHN)/Nurse Practitioner.

Proponent and exception authority. Not applicable.

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I. Purpose.

To provide installation commanders with general guidance on an Individual Assessment Program which will assist them in implementing the health promotion program. This module should be adapted to meet the specific installation's needs.

II. Applicability.

This guidance applies to installation commanders and members of installation/community health promotion councils. This includes but is not limited to: Director of Personnel and Community Activities (DPCA); Director of Logistics (DOL); Public Affairs Officer (PAO); Chief, Family Support Division (FSD); Chief, Community Operations Division (COD); Commander, Medical Treatment Facility (MTF); Director, Plans, Training, and Mobilization (DPTM); Civilian Personnel Officer (CPO); Chief, Community Mental Health Service (CMHS); Chief, Community Relations Division (CRD); Alcohol and Drug Abuse Prevention Control Program (ADAPCP) Officer; Field Director, American Red Cross (ARC); Dietitian; Community Health Nurse (CHN)/Nurse Practitioner.

III. Background.

A Health Risk Appraisal (HRA) (medical evaluation and questionnaire) is a tool designed to evaluate an individual's health risks based upon his/her lifestyle habits, personal medical history, and family medical history. This tool is an important component of the Fit To Win Program. The health risk appraisal (HRA) gives feedback to the individual soldier, Army civilian or family member. It also provides direction and motivation to initiate risk reducing behaviors. The HRA provides aggregate data allowing commanders and leaders to check on overall program progress.

IV. Goals.

The goals of the Individual Assessment Program include the development of:

- A Total Army Family which is aware of individual health risk factors which can be associated with disease, injury, and death.
- Methods which direct individuals towards specific risk factor modification interventions.
- Programs which acquire data across all age groups and aid in the identification of specific risk factors.

V. Responsibilities.

a. Commanders at all levels are responsible for the Individual Assessment Program implementation and the accomplishment of the objectives including evaluation of the program and its impact within their organization.

b. Commanders at brigade and lower levels will use their assets (physician assistants, medical corpsmen, unit ministry teams, master fitness trainers) to teach and promote better health and fitness. Commanders at installation and community level will assist with assets to meet needs not available at brigade or lower levels.

c. The Health Promotion Council will, through coordinated efforts of the members, act as a central focal point for program information and advice to the commander.

d. The Commander of the Medical Treatment Facility will monitor the health status and relevant health risks in the command, provide technical consultation regarding education, information and intervention programs, operate targeted lifestyle programs requiring medical supervision, and obtain aggregate data for use by the Installation Commander.

e. Installation programs will include all the elements of a level one program. Then, based on a community needs assessment, (Marketing Module) programs can be expanded to include components of level 2 and 3 programs. Figure 1 depicts suggested elements for various levels of the Fit To Win Program.

Suggested Elements for Level 1-2-3 Fit To Win Programs

Modules	Level 1 Program	Level 2 Program	Level 3 Program
Commander's Guide	Introductory chapter Strategies for program management and resources	Same as Level 1	Same as Level 1
Marketing	Unit briefings Post media Community needs assessment Posters, slides, videotapes Incentives: — Personal recognition certificates — Awards Evaluation Strategies	Level 1 plus: Guest speakers Promotional items	Level 2 plus: Public relations campaigns Support groups Intramural competitions
Individual Assessment	Automated Health Risk Appraisal Health Risk Review Session	Same as Level 1	Same as Level 1
Physical Conditioning*	Community/unit based programs to include aerobic and strength development classes AR 350-15 Guidance National Fitness Month	Level 1 plus: Individualized prescription based on fitness evaluation	Same as Level 2
Nutrition and Weight Control	Pamphlets/posters Media blitz for dining hall: menus National Nutrition Month AR 600-9 Guidance	Level 1 plus: Group classes Videotapes Slides/Cassette tapes	Level 2 plus: Nutritional Assessment Individualized diet plans Computerized nutritional analysis Cooking classes
Antitobacco	Pamphlets/ brochures Media blitz advice for smokers and non-smokers National Smokeout AR 1-8 Guidance	Level 1 plus: Group cessation programs Videotapes Radio/TV spots	Level 2 plus: Computerized cessation program Support group

Figure 1. Suggested Elements for Level 1–2–3 Fit To Win Programs

Modules	Level 1 Program	Level 2 Program	Level 3 Program
Stress Management	Pamphlets/brochures Posters Welcome Packets with resources within the community Sponsorship Program associated with PCSs	Level 1 plus: Group classes Videotapes Radio/TV spots Commanders session's Unit training Community Skill/Activity Classes	Level 2 plus: Individual treatment programs conducted at Medical Treatment Facility
Hypertension Management	Pamphlets/brochures Unit level Monitoring National High Blood Pressure Month (May) Periodic B.P. checks/follow-ups	Level 1 plus: Group classes Videotapes TV, radio spots	Level 2 plus: Individual counseling
Substance Abuse Prevention	Pamphlets/brochures Posters Group meetings and classes AR 600-85 Guidance	Level 1 plus: Videotapes	Level 2 plus: Individual counseling Support groups
Spiritual Fitness	Pamphlets/brochures Posters Opportunities to meditate, pray, or worship AR 165-20	Level 1 plus: Group meetings classes Developmental activities	Level 2 plus: Individual counseling Referral agencies Values building resources Support groups
Dental Health	Pamphlets/brochures National Children's Dental Health Month Periodic Dental Examinations Unit Level Dental Fitness Classification Monitoring	Classes Videotapes Radio/TV spots Skills Classes	Individual Oral Hygiene Counseling Definitive Dental Treatment Long Term Follow-Up
Procedures Guide	Pamphlets/ Brochures/Posters Command Briefings (at least monthly) Incentive/Sustainment Program	Unit Training Schedules which reflect health promotion education classes in all areas needed	Unit Days for: Health Risk Assessment Family Health Promotion Activities

*The exercise elements are the most likely to result in untoward events; therefore, cardiovascular screening must be required for all individuals 40 years of age and older and for anyone with a history of cardiovascular disease. A disclaimer is required.

Figure 1. Suggested Elements for Level 1–2–3 Fit To Win Programs — Continued

VI. An Overview of the Army Health Fitness Process.

a. The Army health fitness process (Figure 2) provides a concise view of:

(1) A logical, sequential series of stages to access individual soldiers, Army civilians, and family members into the program.

(2) Assessing current level of health/fitness.

(3) Managing the data obtained.

(4) Evaluating their health profile against predetermined standards.

(5) Conducting appropriate targeted interventions to address individual needs.

(6) Reevaluating as necessary.

b. The program's primary emphasis is on assessment and education only. Assessment is accomplished through completion of periodic health risk appraisals for all soldiers, Army civilians, and family members.

c. A variety of ways exist to enter the program. This is done through a health risk assessment conducted when in processing (upon PCS), in conjunction with periodic physical exams, or upon accession into the Army. In addition, an individual may enter the program through unit initiated referral or self referral.

d. The health risk appraisal questionnaire, an automated, personalized instrument, asks the individual participant to respond to questions about personal and family health history, lifestyle, and attitudes. Other data, such as height, weight, blood pressure, and cholesterol level are also entered. Figure 2 depicts the assessment process. These data are stored and managed at both the installation/community level and in an Army-wide database. Aggregate data are used by commanders to monitor wellbeing.

e. A health risk appraisal profile, compiled and printed by the automation process, is given to the individual and another is placed in the person's medical record. The participant is given an outbrief of HRA results to provide assistance in interpreting the HRA profile. At this time opportunities are given for medical and educational interventions.

f. The profile is used to determine which interventions, if any, are needed. Individuals requiring medical interventions, for example, those with high cholesterol or blood pressure are referred to a health care provider for a consultation. Appropriate health education interventions are then conducted in the community or at the unit level. These consist of physical conditioning nutrition/weight control, anti tobacco use, stress management, hypertension management, substance abuse prevention and spiritual fitness.

g. Individual reevaluation occurs with the completion of the periodic health risk appraisal. Health risk appraisals are given not more than once a year and not longer than one every three years. Figure 3 shows the relationship of these three phases.

Assessment Process

Health Risk Appraisal Program Preparation

- HRA Questionnaire Completion
 - Measurement
 - Height/Weight
 - Blood Pressure
 - Heart Rate
 - Blood Draw
 - Cholesterol
 - HDL (if directed)
 - Fasting Blood Sugar (if directed)
-

Computer Run of Results

Figure 2. Assessment Process

VII. Module Elements.

This module is comprised of the following areas:

Awareness	Annex A
Risk Factor Identification	Annex B
Intervention/Education	Annex C
Evaluation	Annex D
Standard Operating Procedures	Annex E

Health Promotion Process

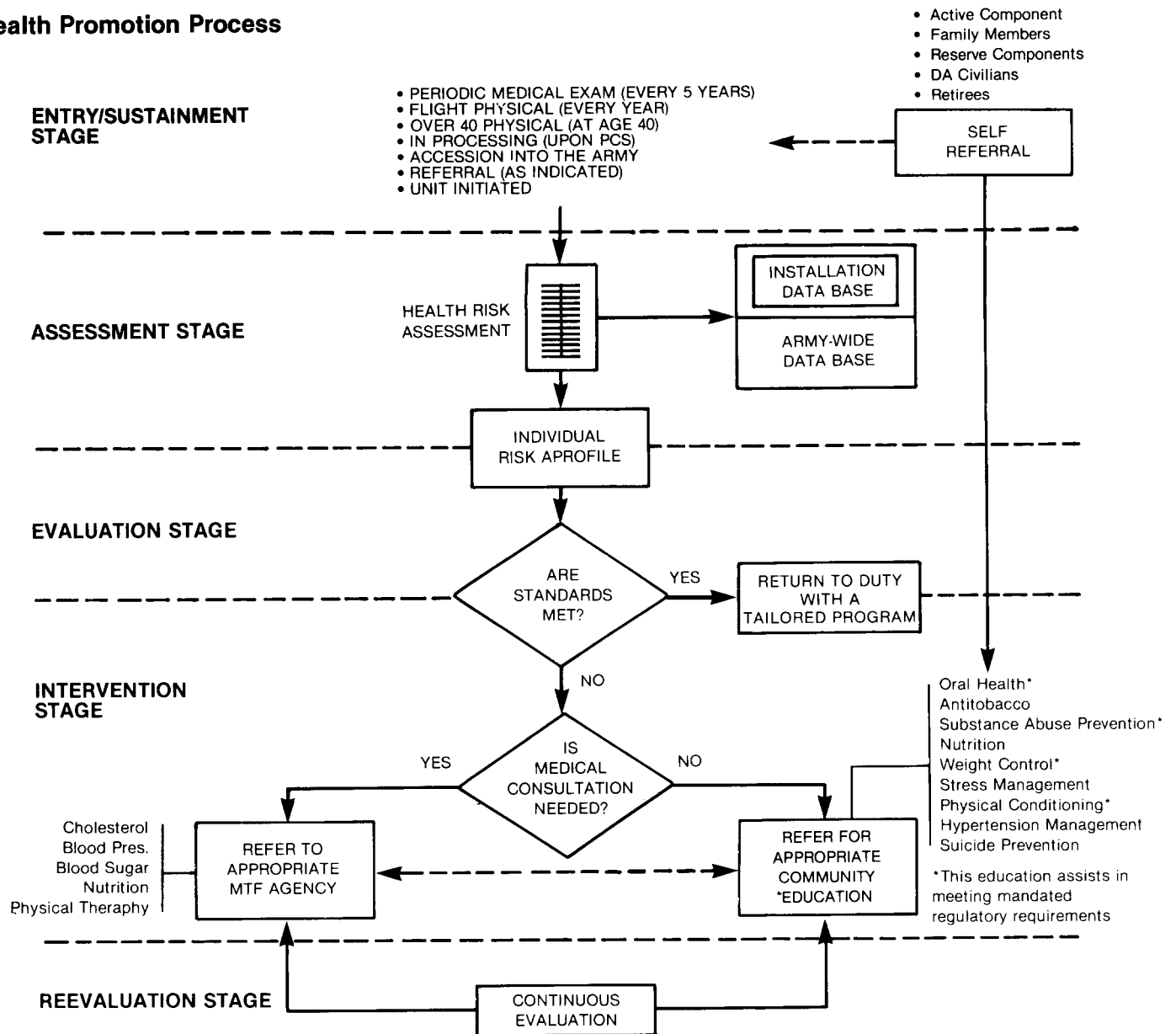


Figure 3. Health Promotion Process

Appendix A

Annex A — Awareness

A–1. Awareness

a. Lifestyle habits play a major role in influencing an individual's risk of developing many diseases and of dying of these diseases. In individuals under 65 years of age, 53% of all deaths are lifestyle-related. Behavior change is the key to reducing lifestyle-related disease and to improving quality of life.

b. Motivation is an integral part of changing an individual's behavior and stimulating the adaptation to perform good health habits. One important influence in motivating an individual to initiate change is to make that person aware of his/her health risk factors. By establishing personal relevancy, or awareness, many individuals will want to make positive behavioral changes. By directing these individuals into appropriate and available education programs as soon as possible, the momentum for change will continue. This awareness phase can be achieved in these two ways; Community/Installation Campaign and Worksheet Target Groups.

A–2. Community/Installation Campaign.

A community/installation campaign will be conducted to direct attention toward the Fit To Win Program. The Marketing Module covers a number of strategies designed for this particular purpose.

A–3. Worksheet Target Group

Specific groups may be targeted for education based on a community needs assessment (See Marketing Module), from the aggregate data obtained from the health risk appraisals, or from the commander's use of DA Pam 600–69, Unit Climate Profile. Once these groups are identified, efforts must be coordinated through the Health Promotion Council to develop campaigns toward that group. The Marketing Module, as well as specific health education modules, addresses targeting strategies for different health risks.

Appendix B

Annex B — Risk Factor Identification

B–1. Risk Factor Identification

a. Ultimately, the individual is responsible for ensuring his/her own health, but every effort must be made to equip the individual with the necessary knowledge to make healthy lifestyle choices. This is a command responsibility since the health of the Total Army Family must be maintained and improved for the sake of readiness.

b. One of the first tasks in supplying the individual with healthy lifestyle knowledge is to make the person aware of his/her own health risk factors. These risk factors must be identified before a suitable intervention can be made to improve the individual's health. A number of ways are available to identify risk factors in an individual:

- Health Risk Appraisal Instrument
- Periodic Examination
- Routine Referral
- Self-Referral

B–2. The Health Risk Appraisal Instrument

a. A health risk appraisal instrument is a valuable tool in the individual assessment phase of a health fitness program. It serves to:

- Increase self-awareness about lifestyle as it relates to health and precursors of disease.
- Identify areas of the individual's lifestyle which, if modified, could improve health and quality of life.
- Motivate individuals to participate in specific intervention programs.

b. The automated health risk appraisal (HRA) is designed for Army wide use as a part of the periodic exam (every 5 years), flight physicals (every year), in processing upon a PCS move, accession into the Army, and self or unit referral. The HRA will remain part of the medical purview and will serve in the initial identification of health risks. The use of this standardized instrument will facilitate the collection of data on lifestyle risk factors in unit(s), commands(s), and the Army. Such data will be useful in:

- Program and resource planning
- Evaluation of intervention programs
- Developing trends in lifestyle risk factors

- Evaluation of organizational readiness

B-3. Periodic Examination.

The physical examination affords the health care provider an opportunity to assess an individual's health status and to recommend lifestyle changes to improve health. Many potentially debilitating disorders are prevented by early identification of risk factors during a physical examination. Health care providers must take this opportunity to intervene when such health risks become evident.

B-4. Routine Referral.

Some problems are apparent outside of the health care system such as identifying an overweight soldier in a unit inspection. These individuals can be referred for the appropriate intervention. Routine referrals are usually targeted at improving one specific problem and do not substitute for an integrated evaluation of an individual's lifestyle activities which promote health or potential disease.

B-5. Self-Referral.

An individual is capable of identifying health risks on his/her own. Frequently, an individual will recognize the need to make lifestyle changes in order to improve his/her health. This usually occurs when the individual has had an experience which creates the desire for change. The individual can then enter an intervention program through a self referral mechanism by contacting the installation health promotion council or unit representative. Self referral is one method of entry into the program for Army civilians, retirees, and family members. They may also be referred by organizations and agencies as a group.

Appendix C

Annex C — Intervention Based on Priority

C-1. Intervention Based on Priority.

a. An individual may have more than one health risk factor identified. The individual should be referred for interventions based on the priority of the risk factors identified, by the HRA team. Interventions should be attended one at a time to ensure the individual's undivided attention and to attain maximum potential for change.

b. Intervention strategies range in spectrum from self-help programs to specialized treatment at a medical facility. Interventions available to the individual include:

- Individual's Fit To Win Handbook
- Intervention program (classes)
- Referral to medical care
- Individual counseling

c. Determination of which intervention strategy is appropriate for a specific risk factor is based on the type of problem, the seriousness of the problem, and the individual's capability for improvement.

C-2. Self-Help Handbook.

a. The Individual's Fit To Win Handbook provides the individual with the basic knowledge needed to being a self-help program. It reviews all the major risk factors in lifestyle behaviors and presents simple, direct instructions for making positive changes. The handbook can be distributed to the individual without any other intervention.

b. Individuals identified with specific high risk health care problems should be referred to the appropriate health care provider. Individuals should be cautioned not to take medical care into their own hands. This handbook is not a substitute for more formalized intervention programs, but is an initial guide and resource book for participants.

C-3. Intervention Program.

An intervention program is a specially designed program of health education ranging from a one-hour class to a formalized block of instruction lasting several weeks. Some risk factors lend themselves to longer interventions due to the nature of the problem, such as weight reduction. Each risk factor should be matched to a specific intervention which serves to meet the individual's need.

C-4. Referral To Medical Care.

Medical referrals should be given for factors that are considered to place the individual at increased risk and that will require further follow-up, such as elevated blood pressure. Guidelines for referral are listed in the procedures annex. Clearance screening for physical conditioning should be accomplished by a health care provider. All civilians assigned to an exercise program and all military over 40, must be cleared before embarking in any physical conditioning

interventions (civilians will accomplish this through their private health care providers). These are safety features of a health promotion program that can not be ignored.

C-5. Individual Counseling.

Participants that have specific risk factor problems may need individual attention. Individual counseling should be afforded when qualified instructors are available. Nutritional counseling and stress management are areas often best suited to individual counseling. This can be supported with classroom instruction.

Appendix D

Annex D — Evaluation

Evaluation is essential to ensure that an integrated individual health fitness program is achieved. At the completion of an intervention, the individual should be reevaluated to assess the impact of the intervention. Re testing, follow-up, and reentry are three methods of evaluation.

D-1. Retest

Retest includes re-assessing the individual completely in all areas to determine the impact of interventions on lifestyle of behaviors. A cause-and-effect relationship cannot be assumed but at least change can be determined. This can be done during periodic physical examinations.

D-2. Follow-Up

Chronic problems may require long term follow-up by health care providers to assess trends in the individual's health. A problem can be followed to ensure stability of the problem such as with high blood pressure. An individual may have high blood pressure but it is controlled by medication, diet modification and weight reduction. Follow-up, in this case, ensures that the problem does not become acute and that it is, in fact, controlled.

D-3. Reentry

Once one health risk factor is under the individual's control or eliminated, he/she can begin to work at changing other behaviors. An individual should be reentered in the intervention system if the original problem reoccurs or to begin working on another health goal.

Appendix E
Annex E — Standing Operating Procedure (sample)

E-1. Standing Operating Procedure (sample)

Standing Operating Procedure (Sample)	Standing Operating Procedure (Sample)
Scope of Practice	Participant Flow
I. Purpose	I. Purpose
To provide guidelines for the Scope of Practice in the Fit To Win Program.	To insure the timely flow of participants thru the Fit To Win Program station.
II. Applicability	II. Applicability
All personnel performing procedures in the Fit To Win Program.	All personnel involved with the flow of participants thru the "One Stop" station.
III. Responsibilities/Procedures	III. Responsibilities/Procedures
A. Procedures to be performed by a health care provider. (91B, 91C) <ol style="list-style-type: none"> 1) Blood Pressures 2) Heights, weights 3) Finger stick blood drawing 4) Cholesterol analysis using Borhinger Mannheim Diagnostics Reflotron 5) Interpretation of health risk appraisal 6) Client health/fitness promotion planning and education 	A. Fit To Win participants <ol style="list-style-type: none"> 1) Participants will be referred to the program during inprocessing, upon physical examination or unit/self-referral. 2) It is the responsibility of the active duty person to report in a timely manner to the Fit To Win Station.
B. Procedure to be performed by an administrative clerk. <ol style="list-style-type: none"> 1) Administer health risk appraisal (HRA) questionnaire to participants, insure proper completion. 2) Input HRA into programmed computer system. 3) Compile HRA profiles and prepare for distribution to participants. 	B. Fit To Win Staff <ol style="list-style-type: none"> 1) The Fit To Win staff will insure that all participants once reporting to the station, complete each substation in an expedient manner and in the correct sequence. 2) The correct sequence of substations that must be completed is as follows: (see attached) <ol style="list-style-type: none"> a. Enter, sign-in, obtain HRA b. Complete and turn in HRA c. Cholesterol analysis d. Obtain blood pressure, height, and weight e. Input HRA data into computer f. Outbrief HRA data, consult as appropriate, sign out, exit

Figure E-1. Annex E

FIT TO WIN STATION

"ONE-STOP" PROCESS

Note: Requires Zenith Model 248 MICRO Computer, Card reader, Printer & Reflotron Blood Analyzer

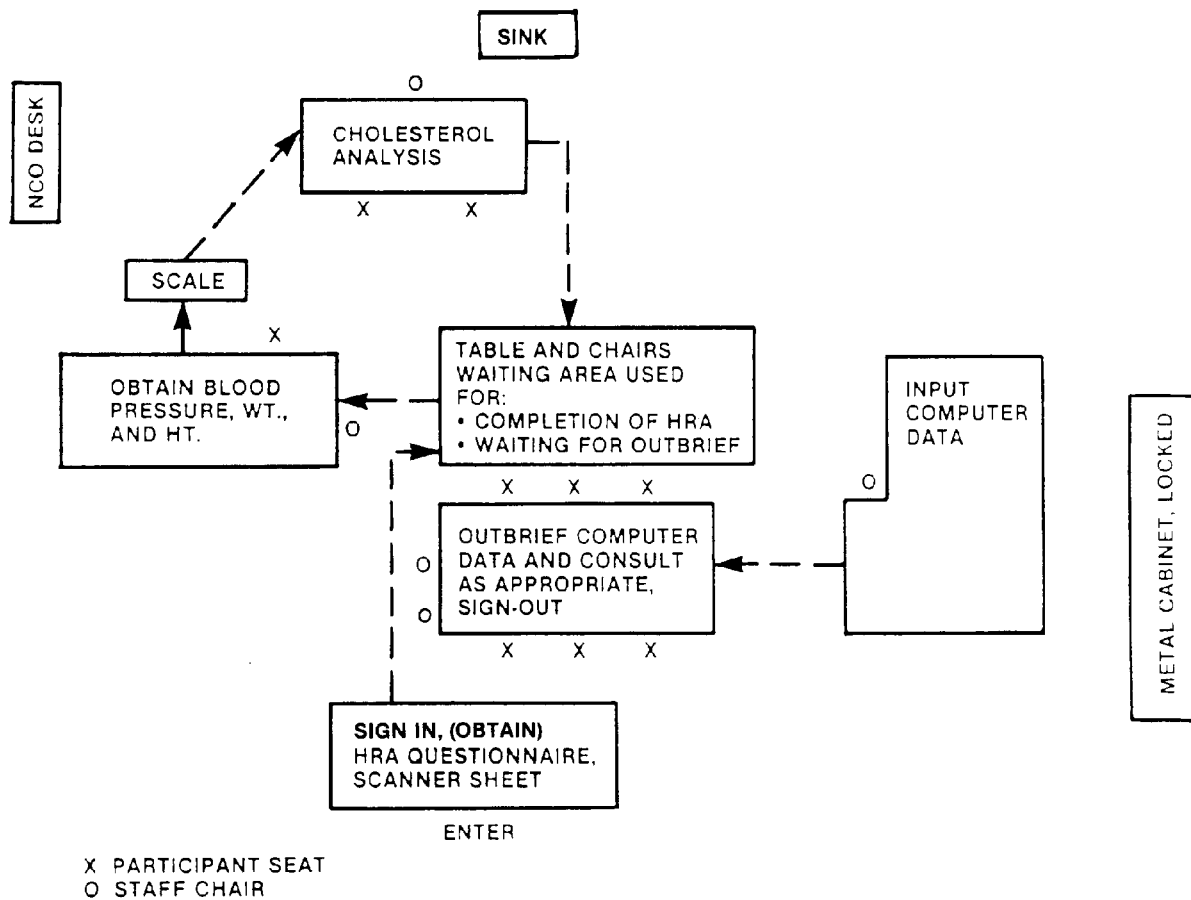


Figure E-1. Annex E — Continued.

Standing Operating Procedure (Sample)

Assessment of Height and Weight**I. Purpose**

To establish a protocol of assessing height and weight in the Fit To Win Program.

II. Applicability

All Fit To Win Personnel assisting with height and weight evaluations.

III. Responsibilities/Procedures

- A. All participants in Fit To Win will have his/her height and weight assessed and recorded entering the program.
- B. Height and weights will be recorded on the HRA.
- C. Heights and weights will be measured in the uniform of the day in an effort to expedite clinic procedures.
- D. When military personnel cannot be weighed in exercise clothing, the staff may subtract 12.0 pounds if the active duty member is in BDU's or 4.5 pounds if he/she is in greens.
- E. In an effort to obtain a more realistic height, subtract one inch from his height if the client is measured in boots or shoes.

Standing Operating Procedure (Sample)

Assessment of Blood Pressures**I. Purpose**

To establish a protocol for determining blood pressures of Fit To Win participants.

II. Applicability

All Fit To Win Personnel who assess participant blood pressures.

III. Responsibilities/Procedures

- A. Each participant in Fit To Win will have his/her blood pressure measured and recorded on the HRA upon entering the program.
- B. Blood pressures will be assessed by credentialed staff only, to ensure accuracy of blood pressures.
- C. The appropriate blood pressure cuff size will be selected as dictated by the participant's upper arm size. Arm circumference will be measured mid way between the antecubital space and the axilla. Cuff size will be selected as follows:

Arm size	Cuff size
5-13 cm	child
14-32 cm	Regular Adult
33-52 cm	Large Adult
> 52 cm	Thigh

Figure E-1. Annex E — Continued.

-
- D. All participants will have their blood pressures taken while in a sitting position.
 - E. The tubing for the sphygmomanometer bulb and gauge will be placed above the brachial artery, in the antecubital fossa.
 - F. The staff member will auscultate the blood pressure with the diaphragm of the stethoscope placed over the brachial artery in the antecubital space.
 - G. If the participants blood pressure is greater than 140/90, he/she will be allowed to relax for 10 minutes. The pressure measurement will be repeated. The lower of the two readings will be recorded on the HRA.

Standing Operating Procedure (Sample)

Assessing Cholesterol Level

I. Purpose

To establish a protocol for determining serum cholesterol levels using the Boehringer Mannheim Reflotron Cholesterol Analyzer.

II. Applicability

All Fit To Win personnel who assess participant cholesterol levels.

III. Responsibility/Procedure

- A. Each participant in the Fit To Win program will have his/her cholesterol level determined and recorded on the HRA upon entering the program.
- B. Serum cholesterol levels will be assessed by credentialed staff only. This will ensure accuracy, and preserve aseptic technique.
- C. Screening cholesterol levels do not need to be done on fasting specimens.
- D. Blood will be collected by obtaining a finger stick capillary specimen. This will be done as follows:
 - 1) Clean finger tip surface with alcohol swab
 - 2) Using lancet, pierce finger once. Autoclic or other skin piercing device may be used when available.
 - 3) Lancets will only be used once and then discarded in a specified contaminated needle container.
 - 4) A large droplet of blood is required. To augment blood flow, hold the finger below the level of the heart. Avoid milking the finger as this can cause excess tissue fluids to mix with the blood specimen and produce erroneous results.
 - 5) The blood will be collected in a heparinized capillary tube.
 - 6) Hold the capillary tube at a 45 degree angle and allow the blood to flow up into the tube to the designated fill line.

Figure E-1. Annex E — Continued.

E. Analysis of the specimen will be done as follows:

- 1) Turn on Reflotron Cholesterol Analyzer.
- 2) Deposit entire blood specimen on red area of cholesterol tab.
- 3) Immediately place the tab in the designated Reflotron tab slot until a click is heard.

4) Shut door on Reflotron covering the cholesterol tab.

5) The Reflotron immediately shows a 175 second count down in the digital window once the door is shut.

6) The cholesterol level will be displayed automatically in the digital window at the end of the count down.

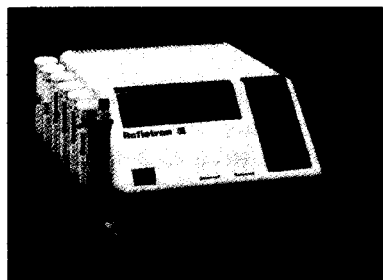
Reflotron®

Whole blood dry chemistry analyzer

Simple to Use

- Switch on the instrument.

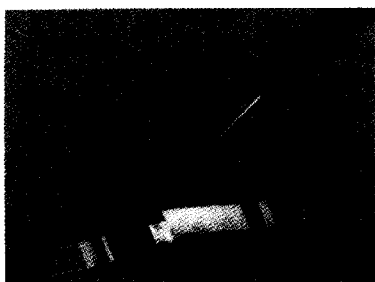
Start-Up



- After a brief warm-up period, "READY" will appear on the display.
- Remove reagent tab from vial and close vial.
- When reagent tab has protective foil, remove foil.

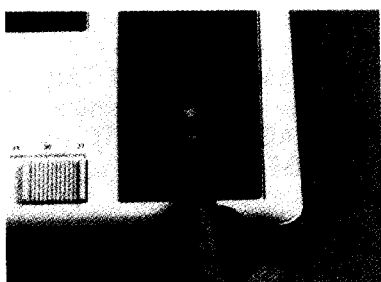
Figure E-1. Annex E — Continued.

Apply Sample



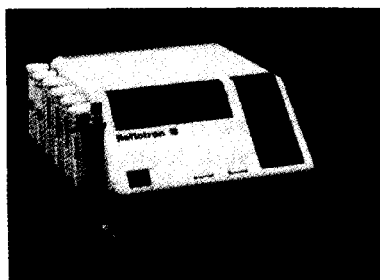
- Carefully draw sample into capillary tube or pipette tip. No air bubbles should be visible.
- Dispense sample onto center of red mesh area of tab using a quick, smooth motion. (See package insert for Hemoglobin.)
- **Do not** allow pipette tip or capillary tube to touch the tab.

Insert Tab



- Immediately insert tab with the reagent pad size up, until a click can be heard.
- When "CLOSE DOOR" appears on the display, close the door.

Read and Discard



- Test name abbreviation and countdown will appear on the display.
- Test results will be displayed automatically.
- Open door, remove tab, and discard.

Figure E-1. Annex E — Continued.

Standing Operating Procedure

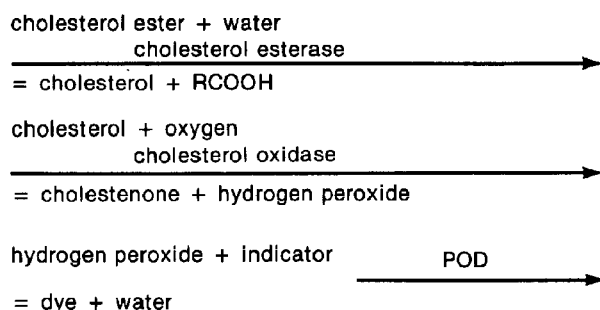
Use of Reflotron Cholesterol Analyzer

Principle

The test pad contains cholesterol esterase, cholesterol oxidase, and an indicator. The test strip separates plasma from whole blood by adhesion of erythrocytes and other particles on the surface of glass fibers.

Under the catalytic action of the enzyme, cholesterol esterase, the cholesterol esters are cleaved into cholesterol and the corresponding fatty acids. In the presence of oxygen, the free cholesterol is oxidized to cholestenone with the aid of the enzyme cholesterol oxidase; the hydrogen peroxide which is formed oxidizes the indicator 3,3',5,5'-tetramethylbenzidine to a blue dye, the concentration of which is determined by reflectance photometry.

The reaction is:



The magnetic code on each strip contains parameter identification as well as all information about the specific reflectance function of the test patches. The magnetic code is read and stored by the Reflotron.

Reagents

The reagent test tabs contain the following:

- Cholesterol esterase (candida cyclindracea) >0.86 U
- Cholesterol oxidase (nocardia erthropolis) >0.072 U
- Peroxidase (horseradish) >0.79 U
- 3,3',5,5'-tetramethylbenzidine >43.2 ug

Non-reactive ingredients: buffer

Storage and Stability:

When stored in the original vital and at the temperature specified (2-30 degrees C), the tabs are stable up to the expiration date given on the pack and vial label. In order to avoid exposure to moisture, the vial must be closed IMMEDIATELY AFTER REMOVAL OF A TAB, using the original stopper which contains a drying agent. BRING REAGENT TABS TO ROOM TEMPERATURE BEFORE PERFORMING ASSAYS.

Quality Control:

- Preparation of Universal Quality Control Serum
 - Carefully open the bottle of control serum, making sure the contents are not spilled.
 - Using the volumetric pipet, pipet 2 ml of distilled water into the bottle of control serum.
 - Close the bottle carefully, do not spill the contents. Gently swirl the bottle avoiding the formation of foam, this should be done until all of the material is dissolved. DO NOT SHAKE THE BOTTLE!
 - Then let the bottle stand for 30 minutes. Again gently swirl the bottle. DO NOT SHAKE THE BOTTLE!
 - The bottle of control serum is now ready for use and can be treated and analyzed like a serum specimen.

Figure E-1. Annex E — Continued.

The expiration date of the lyophilized control serum is given on the pack. **THE CONTROL SERUM SHOULD NOT BE USED PAST ITS EXPIRATION DATE.**

The components of the recommended control serum are stable at least 2 days at refrigerator temperature (+ 4 degrees C). **DO NOT FREEZE THE CONTROL SERUM TO BE USED FOR THE CHOLESTROL TESTING!**

b. Use of the Quality Control Serum

1. The control serum should be used **DAILY** to check the function of the machine and test strips. Run the serum through the testing procedure as you would a patient. If the results are within the range limits, **RECORD THE RESULTS IN THE QUALITY CONTROL LOG.**
2. If the results are outside the range limits repeat the test with a new test strip. If the results are within the range limits, record the results in the Quality Control Log. (Included at end of S.O.P.)
3. If the results are outside the range and after repeating the test with a new teststrip, the results are still outside of the range (a total of 2 teststrips should be used before going to the steps below):
 - I. Make sure proper technique was used.
 - II. Recheck the instrument calibration.
 - III. Recheck the expiration date on the reagent package.
 - IV. Recheck the expiration date on the control package.
 - V. Refer to the Troubleshooting Section of the Reflotron Operator's Manual.
 - VI. Contact the Biomedical Maintenance Section at the Hospital.

Sample Collecton:

- a. When opening a new container of capillary tubes remove the metal cap. Now remove the foam disc from the container. Replace the metal cap. The capillary tubes can now be dispensed individually through the hole in the top of the container. The capillary tubes are coated with lithuim-heparin as the anticoagulant.
- b. Loosen the collet (knurled tip) of the pipette with 1/2 turn counterclockwise.
- c. Insert the colored portion of the capillary tube into the end of the pipettor carefully. Slide the capillary tube in until the black calibration line is flush with the end of the collet. Ensure the capillary tube is seated up against the stop.
- d. Tighten the collet by turning it clockwise until snug.
- e. Obtain the capillary blood sample according to standard laboratory practices.
- f. Touch the end of the capillary tube to the capillary blood sample. The blood will be drawn up the tube via capillary action; allow filling to the 30 uL calibration line.
- g. Wipe any excess blood from the end of the tube with a lint-free tissue. Do not touch the blood sample in the tube with the tissue.
- h. Take a cholesterol reagent tab out of the vial. **CLOSE THE VIAL IMMEDIATELY WITH THE DESSICANT STOPPER.**
- i. Remove the foil protecting the test area on the reagent tab.

Figure E-1. Annex E — Continued.

-
- | | |
|--|--|
| <p>j. Dispense the sample onto the center of the mesh red separation zone. Do not touch the red mesh with the end of the capillary tube; let the blood sample form a drop and touch the center of the separation zone. PRECAUTION: IF A CLOT IS OBSERVED IN THE CAPILLARY TUBE PLEASE DISCARD THE SAMPLE AND COLLECT THE SAMPLE AGAIN. IF A PORTION OF BLOOD HAS ALREADY BEEN PLACED ON THE REAGENT TAB AND A CLOT IS OBSERVED, DISCARD THE TAB AND CAPILLARY TUBE AND RECOLLECT THE SAMPLE.</p> <p>k. WITHIN 15 SECONDS, place the tab on the guide and insert horizontally into the instrument until you hear a click. The instrument will then display "CLOSE DOOR".</p> <p>l. Close the sample door.</p> <p>m. The time before the results appear is displayed in seconds.</p> <p>n. The cholesterol concentration is displayed in mg/dl or mmol/L depending upon the units selected. Record the results.</p> <p>o. Raise the sample door and discard the tab. Observe the reagent tab. Deeply colored single points on the test area may signal questionable results; these are usually caused by improper placement of the sample. Discard the reagent tab and repeat the assay if this occurs. Otherwise, the results are acceptable and you the reagent tab may be discarded and the next sample may be run.</p> | <p>Limitations of the procedure (Per product literature):</p> <p>a. Hematocrits of up to 55% do not affect the results.</p> <p>b. No interference was found in lipemic samples containing up to 1500 mg/dl of triglycerides.</p> <p>c. Capillary samples must be obtained from free flowing capillary blood. EXCESSIVE SQUEEZING AND MILKING WILL PRODUCE ERRONEOUS RESULTS.</p> <p>d. The following substances, when present in high concentration, may produce depressed cholesterol values: cystine, ascorbic acid, methylodopa, gentisic acid, dipyrone, ampyrone, homogentisic acid and glutathione.</p> <p>e. Hemolyzed samples should not be used.</p> <p>f. When stored in the original vial and at the temperature specified, the tabs are stable up to the expiration date given on the pack and vial label.</p> <p>g. If the value obtained on an individual specimen is unusually low (100 mg/dl or less) repeat the test with a new, unused reagent tab and fresh sample.</p> <p>h. Use the Reflotron Capillary Pipettor only when performing the capillary samples. When pipetting serum, plasma and controls use the Reflotron Pipette.</p> |
|--|--|

Figure E-1. Annex E — Continued.

Performance Characteristics

- a. Measuring range: 100.0 — 500 mg/dl (2.6 — 12.9 mmol/L)

References

1. Siedel, J. et al., Clinical Chemistry 29 (1983) 1075.
2. Trinder, P., Analytical Clinical Biochemistry, 6 (1969) 24.
3. Roschlau, P. et al., Z. Klin. Biochem. 12 (1974) 403.

Specimen requirements:

Fresh capillary blood by fingerstick; should be used for testing within 2-3 minutes. EXCESS SQUEEZING AND MILKING OF THE PUNCTURE SITE WILL PRODUCE ERRONEOUS RESULTS.

Expected Values (from package insert)

A consensus development panel of the National Institutes of Health has determined that the elevation of blood cholesterol levels is a major cause of coronary heart disease. The panel has established guidelines for moderate and high-risk levels of blood cholesterol, which have been summarized in the table below:

AGE	MODERATE RISK	HIGH RISK
2-19	170 mg/dl	185 mg/dl
20-29	200 mg/dl	220 mg/dl
30-39	220 mg/dl	240 mg/dl
40 and over	240 mg/dl	260 mg/dl

(High Cholesterol values is one of many factor contributing to increased risk of coronary heart disease).

Procedure

Material needed:

- a. Reflotron Cholesterol Reagent Tabs
- b. Capillary Tubes, 30 ul sample size
- c. Reflotron Cholesterol code strips
- d. Reflotron Capillary Pipettor
- e. HEMOLET Capillary Puncture Device
- f. Lancets
- g. Alcohol Prep Pads
- h. 2 × 2 Gauze Pads

Machine start up:

- a. When the power cable has been plugged in, move the power switch to position 1 (1 = ON). All positions on the display light up and then a series follows.
 - b. "REFLOTTRON" is displayed, followed by "WARMING UP 28, _____, _____, _____, 0". The instrument has a warm-up time which depends on the ambient temperature.
 - c. "READY" is displayed after warm-up time expires.
 - d. When "READY" appears on the display, take a code strip out of the Reflotron Cholesterol Code Strips vial.
 - e. Open the sample door (if not already open), place the strip on the guide, and insert the strip horizontally into the instrument until you hear a click.
 - f. Close the door.
 - g. The display "PROGRAM CHOL" confirms that the test-specific magnetic code has been correctly read into the instrument.
-

Figure E-1. Annex E — Continued.

- h. Open the sample door and remove the code strip. Place the strip back into its vial. NOTE: The code strip need only be read once per day, and need not be run before each cholesterol screening test.
- i. The machine is now ready to perform testing on the Quality Control Serum and patients.
- f. Close flap.
- g. The display "CHEK" confirms that the coded data have been correctly read into the instrument.
- h. The time before the result appears is displayed in seconds (example "CHEK 17 sec").

Calibration:

The Reflotron-Check control strip has a grey test area with a defined reflectance value. The back of the strip contains all data necessary for the performance check in the form of a magnetic code. On insertion of the strip, the coded data are read into the instrument, and the Reflotron automatically switches into the check mode and measures the reflectance of the test area at the three different wavelengths: 642 nm (red), 565 nm (green), and 950 nm (infrared). The reflectance obtained are displayed in $\% \times 10$ and are evaluated by means of comparison with the reference values specified on the vial label.

The following procedure is to be performed and RECORDED ON A WEEKLY BASIS:

- a. Switch on the Reflotron and allow the machine to warm-up for 5 minutes.
- b. Take a Reflotron-Check strip out of the vial and close the vial immediately.
- c. DO NOT TOUCH OR WIPE THE GREY TEST AREA!
- d. DO NOT APPLY SAMPLE MATERIAL TO THE GREY TEST AREA!
- e. Insert the Reflotron-Check strip into the instrument as for a normal test.
- i. Display shows results: set of three digit values (example: "CHEK 647 648 642").
- j. Compare each of the 3 values with the corresponding reference values given on the vial label.
- k. If all 3 values displayed are within the specified confidence limits, i.e. between the minimum and maximum values given on the label, the optical system is functioning properly.
- l. If one or more values are outside the specified confidence limits, proceed as follows:
 1. Clean the transporter, upper and lower heater first with a dry, then with a damp cloth (see instruction manual for help if needed).
 2. Allow the instrument to warm up for 5 minutes.
 3. Repeat performance check with a fresh control strip.
- m. If the values displayed are still outside the confidence limits, contact Biomedical Maintenance for help.
 4. Braun, H.P. et al., Clinical Chemistry, 30 (1984) 991.
 5. National Institutes of Health, Lowering Blood Cholesterol to Prevent Heart Disease, JAMA 14 (1985) 253.

Figure E-1. Annex E — Continued.

REVIEWED BY: David

Date: 3/19/87

COMMENTS and/or CHANGES:
Correlation Study Pending at this time.

IMPORTANT

The Fit to Win Station is considered a satellite laboratory of the main MTF laboratory. Appropriate credentialing and quality control measures will be conducted under the control of the MTF laboratory officer.

Standing Operating Procedure (Sample)

Completion of Health Risk Appraisals

I. Purpose

To establish a protocol for completion of Health Risk Appraisals.

II. Applicability

All Fit To Win Personnel involved in assisting participants with completion of HRA's

III. Responsibility/Procedure

- A. Each participant in Fit To Win will complete an HRA upon entering the program.
- B. Fit To Win staff will be responsible for ensuring that all participants have filled out the questionnaires accurately.

- C. All HRA questionnaire answer cards will be completed in #2 lead pencil.

Standing Operating Procedure (Sample)

Input of HRA

I. Purpose

To ensure timely and correct input of HRA's into programmed computer system.

II. Applicability

All Fit To Win personnel who are responsible for input of HRA in Fit To Win programmed computer system.

III. Responsibility/Procedure

- 1) Each Fit To Win participant's HRA questionnaire, will be entered into the Fit To Win computer system without delay.
- 2) Only those staff certified to input HRA's will be allowed to do so.
- 3) A designated automatic card reader will be used to input HRA results.
- 4) Two copies of the HRA will be printed. One copy will go to the participant. The other copy will be placed in the participant's medical record. Civilian participants will be given the second copy to hand carry to their primary health care provider.
- 5) When problems occur with computer software or hardware, the designated Automation Management Officer (AMO) will be notified immediately to resolve the problem. Every effort will be made to minimize down time.

Figure E-1. Annex E — Continued.

Standing Operating Procedure (Sample)

Operating The Zenith 248

I. Purpose

To establish guidelines for the operation of the Zenith 248 microcomputer utilizing the Fit To Win WELLNESS CHECK software.

II. Applicability

Applicable to all Fit To Win personnel responsible for data input.

III. Responsibility/Procedure

A. To power on the Zenith 248 microcomputer and input data:

- 1) Power on equipment by switching on the surge suppressor.
- 2) Insure the printer is ON LINE and paper is properly aligned.
- 3) A series of screens will appear instructing operator to key in information or "strike a key when ready. . ."
- 4) When the WELLCHECK MAIN MENU (colored menu) appears enter 1 and press (enter).
- 5) At the next MAIN MENU screen the default option is 1 for INDIVIDUAL CASE PROCESSING. Press (enter) to continue.
- 6) At the PROCESSING MENU the default option is 1 for CARD VERSION. Press (enter) to continue.
- 7) Continue through the next series of screens inputting the required information when prompt.
- 8) When prompted by the system insert a card (right side up and question #1 toward card reader). Card will be read and checked for errors. If no errors are found report will be printed automatically.

B. To end card reading session:

- 1) Insert the STOP PROCESSING CARD (any card with 2 blocks filled on question #1). When the message "Question #1 Does Not Have An Acceptable Value" appears on the screen press (enter) to return to the WELLCHECK MAIN MENU (colored menu).

C. Reports generation:

- 1) At the WELLCHECK MAIN MENU (colored menu) enter 1 and press (enter).
- 2) At the MAIN MENU screen enter option 2 for GROUP REPORTS AND FINDINGS.
- 3) Follow instructions as indicated on the next series of screens.

D. To open new or different data file:

- 1) At the WELLCHECK MAIN MENU (colored menu) enter 1 and press (enter).
- 2) At the next MAIN MENU screen enter option 3 for UTILITIES.
- 3) Enter option 3 at UTILITIES MENU screen.
- 4) At the DATA FILE OPENER screen enter the number of the file to be opened (e.g. 001) press (enter).
- 5) Follow screen instructions to return to the MAIN MENU screen.

E. End of duty day procedures:

- 1) End card reading session.
- 2) Complete the WELLNESS CHECK DATA LOG.
- 3) Power off equipment by switching off the surge protector.

Figure E-1. Annex E — Continued.

Standing Operating Procedure (Sample)

Outbrief of HRA Results

I. Purpose

To ensure that the participant is provided with adequate assistance in interpreting his/her HRA and is given appropriate educational and medical intervention opportunities.

II. Applicability

All Fit To Win Staff who are responsible for outbrief of HRA.

III. Responsibility/Procedure

1. Each Fit To Win participant will be given assistance in interpreting his/her HRA results.
 2. General interpretation of HRA results may be done individually or in group format providing that the confidentiality of participant's results is maintained.
 3. Interpretation of HRA's and participant intervention plans will only be done by credentialed (see credentialing S.O.P.) Fit To Win Staff.
 4. Participant interventions such as educational or medical consultations and special verbal/written instructions will be documented by the Fit To Win Staff on both HRA copies. The staff member will then initial the HRAs.
 5. A daily log of participants receiving outbriefing consultations will be maintained. The log must contain name, social security number, unit, and specific health risk. A sample form is provided at the end of the module.
6. The following topics may be discussed, but are not limited to:
 - a. Smoking Cessation
 - b. Blood Pressure/Hypertension
 - c. Stress Management
 - d. Alcohol and Drug Use
 - e. Seat Belt Use
 - f. Colon Cancer Screening
 - g. Weight Control/Basic Nutrition
 - h. Cholesterol
 - i. Heart Risks
 - j. Caffeine Intake
 - k. Exercise/Physical Training
 - l. Monthly Self Breast Exam, regular PAP Screening
 - m. Self-Testicular Exam
 7. If the HRA recommends lifestyle changes in the areas noted in #6 the participant will be managed in the following manner:
 - a. Smoking
 1. Participants will be advised to stop smoking.
 2. Rationale may be given for smoking cessation.
 3. Supportive anti-smoking literature may be given.
 4. All participants who smoke will be provided with a consultation to enter a smoking cessation program, provided at the unit or community level.
 - b. Blood Pressure/Hypertension (HTN)
 1. Participants will be instructed on the recommended normal blood pressure range as compared to his current blood pressure. (Normal range = less than 140/90).

Figure E-1. Annex E — Continued.

-
2. If the participant has a documented history of HTN and is/is not currently under a doctor's care, he will be referred to his TMC/MTF for follow-up.
 3. If the participant's blood pressure is greater than or equal to 210 mm Hg systolic or 110 mm Hg diastolic, he/she will be referred to the TMC/MTF or their primary health care provider immediately for medical follow-up.
 4. If the participant has no documented history of HTN and his/her systolic pressure is greater than 140 mm Hg, the diastolic pressure is greater than 90 mm Hg, he/she will be given 10 minutes to relax and the blood pressure will be repeated. If his/her blood pressure still exceeds the above limits, he will be referred to his/her TMC/MTF or primary health care provider for a three day blood pressure check and follow-up as needed.
 5. The participant should be provided with brief instructions regarding hypertension risk factors and methods of blood pressure management. These instructions may be given in written or oral form.
- c. Stress Management
1. The importance of stress management will be emphasized.
 2. Supportive literature may be provided.
 3. Targetted participants will be provided consultation to enter a stress management program. If the participant wishes to enter such a program he/she will be given information on unit and community level stress management programs.
 4. Consultation to stress management will be highly encouraged if the participant exhibits four or more indicators of stress, or has considered suicide in the last 2 years.
- d. Alcohol and Drug Use
1. The importance of limiting alcohol use to no greater than one drink per day will be discussed.
 2. Illicit drug use will be discouraged.
 3. Participants will be provided an opportunity to receive supportive literature on request.
 4. Consults for substance abuse follow-up may be written on the request of the participant. Consults should be addressed to the Fit To Win Coordinator.
- e. Seat Belt Use
1. Participants will be encouraged to use seat belts 100% of the time.
 2. Participants will be provided an opportunity to receive supportive literature.
- f. Colon Cancer Screening
1. Participants will be encouraged to have Colon Cancer Screenings annually after the age of forty.
 2. Supportive literature may be given if available.
 3. If the participant requests a medical screening, he/she will be consulted to his/her TMC/MTF, or primary health care provider.

Figure E-1. Annex E — Continued.

-
4. The participant will be highly encouraged to seek medical intervention if he/she is over 40 and has a family history of colon cancer.

nutrition programs, and will be referred to their TMC/MTF or primary health care provider:

g. Weight Control/Basic Nutrition

1. Participants will be encouraged to maintain and or achieve their ideal body weight and composition.
2. Supportive literature may be provided regarding ideal body weights, composition, Army weight standards, guidelines for weight loss and components of a prudent diet.
3. Targeted participants will be provided a consultation to enter a weight reduction program . If he/she so desires, the participant will be given a consult to the Clinical Dietitian. Information will be available on unit and community level programs.

Age	Cholesterol
20-29	200
30-39	220
40	240

h. Cholesterol

1. Participants will be instructed on the recommended normal cholesterol ranges as compared to his/her current level (average cholesterol goals = less than 200 mg).
2. Participants should be provided with brief instructions regarding the causes of high cholesterol, the importance of cholesterol reduction and dietary interventions. These instructions may be given in a written or oral form.
3. Participants with the following cholesterol levels will be given a consult to Clinical Dietetics, information on unit and community level

i. Heart Risks

1. Participants will be provided with information on the risk factors for heart disease e.g. family history, smoking, obesity, high blood pressure, stress, high cholesterol and lack of exercise.
2. Participants should be encouraged to reduce as many of these risk factors as possible.
3. Supportive literature may be provided.
4. If participants have a history of recent cardiac warning signals e.g, chest pain, or if the participant has 3 or more risk factors he/she will be referred to his/her TMC/MTF or primary health care provider.
5. Participants will be provided with information on unit and community level programs for risk factor reduction.

j. Caffeine Intake

1. Participants should be encouraged to minimize their caffeine intake to no more than 240 mg. per day or 2 servings of either coffee, tea, sodas, chocolate per day.
2. Supportive literature may be provided when available.

Figure E-1. Annex E — Continued.

k. Exercise/Physical Training

1. Participants will be encouraged to participate in regular aerobic exercise programs at least 3 times per week.
 2. Participants will be given, on request, information regarding training heart rates, PT Standards, basic injury prevention, stretching exercises. This may be in either written or oral format.
 3. If the participants have a recent history of difficulty in their physical training program, recurrent injury or more specific training questions they will be referred to their unit Master Fitness Trainer. If a Master Fitness Trainer is not available, the participant will be referred to the Physical Therapist at his/her TMC/MTF or to his/her primary health care provider.
 4. Participants will be encouraged to incorporate training heart rate information into their daily physical training.
 5. Participants will be provided with the related information on request in either written or oral format.
 6. All civilians will be cleared by their personal physician before embarking on an exercise program. (See sample referral letter).
- l. Self Breast Exam and Regular PAP Screening
1. Female participants will be encouraged to do monthly self breast examinations and have regular PAP smears. The rationale for doing these tests should be emphasized.

2. Supportive literature may be made available.
3. Targeted participants will be given consults for PAP/Breast Exam appointment.

m. Self Testicular Examination

1. Male participants will be encouraged to do Self Testicular Examinations monthly. Rationale for doing this test may be reviewed.
2. Supportive literature may be made available.

n. Spiritual Fitness

1. The importance of spiritual fitness will be emphasized.
 2. Supportive literature will be provided.
 3. If the participant wishes to enter further interventions he/she may be referred to ministry services provided at the Division/Installation Level.
8. In an effort to expedite the consultation process, pre-written consults may be used by the outbriefing staff. They should be dated and signed by the health care provider. (See attached consult samples).
9. Every effort should be made to manage the participant's HRA results and need for future follow-up consultation confidential.

Figure E-1. Annex E — Continued.

FOR FOLLOW-UP, GO TODAY TO ASSIGNED TMC/ER WACH

MEDICAL RECORD		CONSULTATION SHEET	
REQUEST			
TO: TMC/MTF	FROM: <i>(Requesting physician or activity)</i> FIT TO WIN PROGRAM	DATE OF REQUEST Today's Date	
REASON FOR REQUEST <i>(Complaints and findings)</i> <p style="text-align: center;">BLOOD PRESSURE FOUND TO BE EXTREMELY ELEVATED ON ROUTINE SCREENING (____). PLEASE EVALUATE AND FOLLOW—UP.</p>			
PROVISIONAL DIAGNOSIS <p style="text-align: center;">HYPERTENSION</p>			
DOCTOR'S SIGNATURE Dr. Doctor	APPROVED Yes	PLACE OF CONSULTATION <input checked="" type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input checked="" type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <input type="checkbox"/> 72 HOURS <input type="checkbox"/> EMERGENCY
CONSULTATION REPORT			
<p>To be filled out by Health Care Provider</p> <div style="font-size: 4em; transform: rotate(-30deg); opacity: 0.5; pointer-events: none;">SAMPLE</div>			
<i>(Continued on reverse side)</i>			
SIGNATURE AND TITLE To be filled out by Health Care Provider			DATE Anyday
IDENTIFICATION NO	ORGANIZATION	REGISTER NO	WARD NO
PATIENT'S IDENTIFICATION <i>(For typed or written entries give: Name—last, first, middle, grade, rank, rate, hospital or medical facility)</i>			CONSULTATION SHEET STANDARD FORM 513 (Rev. 9-77) Prescribed by GSA/ICMR FPMR 101-11.806-8 513-107

Sample Completed Form

Figure E-1. Annex E — Continued.

MEDICAL RECORD		CONSULTATION SHEET	
REQUEST			
TO: Attn. Lt. Branton PHYSICAL THERAPY	FROM: <i>(Requesting physician or activity)</i> FIT TO WIN PROGRAM	DATE OF REQUEST Today's Date	
REASON FOR REQUEST <i>(Complaints and findings)</i> ON ROUTINE SCREENING, CLIENT FOUND TO HAVE PMH OF PHYSICAL TRAINING DIFFICULTIES, RECURRENT INJURY OR MORE SPECIFIC TRAINING PROBLEM. PLEASE EVALUATE AND TREAT AS NEEDED.			
PROVISIONAL DIAGNOSIS TRAINING INJURY/DIFFICULTY			
DOCTOR'S SIGNATURE Dr. Doctor	APPROVED Yes	PLACE OF CONSULTATION <input type="checkbox"/> BEDSIDE <input checked="" type="checkbox"/> ON CALL	<input type="checkbox"/> ROUTINE <input checked="" type="checkbox"/> TODAY <input type="checkbox"/> 72 HOURS <input type="checkbox"/> EMERGENCY
CONSULTATION REPORT			
<p>To be filled out by Health Care Provider</p> <p style="font-size: 4em; opacity: 0.3; transform: rotate(-30deg); position: absolute; top: 50%; left: 50%;">SAMPLE</p>			
<i>(Continued on reverse side)</i>			
SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO. MED. CLINIC
PATIENT'S IDENTIFICATION <i>(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)</i>			CONSULTATION SHEET STANDARD FORM 513 (Rev. 9-77) Prescribed by GSA/ICMR FPMR 101-11.806-8 513-107

Sample Completed Form

Figure E-1. Annex E — Continued.

Standing Operating Procedure	Standing Operating Procedure
Infection Control	Quality Assurance HRA Follow-up
I. Purpose	I. Purpose
To provide guidelines for infection control for the Fit To Win Program.	To assess the quality of care provided during the Fit To Win outbrief.
II. Applicability	II. Applicability
All Fit To Win staff who obtain blood samples for cholesterol screening.	All staff who perform Fit To Win outbriefs utilizing HRA's, Division Surgeon or Individual Assessment Coordinator.
III. Responsibility/Procedure	III. Responsibility/Procedure
<ol style="list-style-type: none"> 1. Strict hand washing procedures will be observed between each client contact at the cholesterol analysis substation. If a sink is not available, moist towelettes or foam cleanser may be used in place of hand washing. 2. All blood drawing will be done observing strict aseptic technique. 3. Capillary tube holder and autoclave finger puncture devices will be cleaned with alcohol between each patient use. 4. Lancets and capillary tubes will be used once and discarded immediately into a designated contaminated waste product container. 5. Containers used to hold the alcohol and gauze pads will be discarded and replaced at least weekly. Alcohol and gauze pads will be changed daily. 	<ol style="list-style-type: none"> 1. HRA printer cards will have social security numbers recorded on them. These will be stored in Fit To Win files for future research and quality assurance. 2. Every week a percentage of HRA's will be randomly selected from each of the Fit To Win outbriefing staff's clientele by the Fit To Win staff. This will be done prior to submitting the HRA's for inclusion in the health record. 3. Once selected, all HRA's will be reviewed. Appropriateness of treatment plan according to protocols will be assessed. 4. Audit results will be processed according to local quality assurance protocols. 5. Any recommendation comments regarding the HRA reviews will be forwarded to the individual staff member.

Figure E-1. Annex E — Continued.

Standing Operating Procedure (Sample)

Personnel Credentialling/Certification

I. Purpose

To ensure that all Fit To Win Personnel have received adequate training in all aspects of their duties.

II. Applicability

All Fit To Win Staff.

III. Responsibility/Procedure

1. The MTF Credentials Committee will be responsible for credentialling of personnel.
2. Military Fit To Win Staff will be highly encouraged to cross train in all major duties at the Fit to Win Station.
3. Civilian personnel will be credentialled to function only in their assigned duties.
4. Administrative and Medical Staff credentialling/certification will be completed within the first month of employment and will be in accordance with local policy.
5. Administrative staff to include civilians will be minimally certified to:
 - a. Assist in completion of HRA questionnaires.
 - b. Input HRA's into the computer.
 - c. Trouble shoot basic programming.
6. The Administrative Specialist certification procedures will consist of the following:
 - a. Minimum of one week orientation and preceptorship with the designated Automation Management Officer or a previously credentialled Fit To Win Administrative clerk.
 - b. Preceptors will review and demonstrate:
 1. Assistance in completion of HRA questionnaire.
 2. Procedures for data input into computer.
 3. Trouble shooting basic programming problems.
 - c. The new employee will be given an opportunity to practice and to give return demonstrations of all skills listed above in b.
7. Medical staff will be minimally credentialled to perform the following functions:
 - a. Clinical techniques-e.g. blood pressure, height, weight determination.
 - b. Lab technique-e.g. blood collection, cholesterol analysis, cholesterol analysis quality control.
 - c. HRA interpretation and lifestyle intervention planning.
8. The Medical Credentialling procedures will consist of the following:
 - a. A systematic review of the basic components of health/fitness promotion and Fit To Win protocols. This may be done through a self study program where new staff members are given an orientation packet consisting of this information or, when possible formal classes may be scheduled to educate the staff member.
 - b. Once the review of the health/fitness promotion components and Fit To Win protocols has been completed, the employee will be given a written test to validate his knowledge of the topics, as well as his ability to do lifestyle intervention planning. (See sample exam, page 37)
 - c. A minimum of one week orientation/preceptorship with a previously credentialled Fit To Win Fitness Specialist will be scheduled.

Figure E-1. Annex E — Continued.

- d. Preceptors will review and demonstrate:
 1. Clinical techniques of blood pressure, height, weight determination.
 2. Lab techniques consisting of blood collection, cholesterol analysis, daily cholesterol analysis quality control.
 3. HRA interpretation and lifestyle intervention planning.
- e. The new medical employee will be given an opportunity to practice and to give return demonstrations of all skills listed above in section d.
9. Completion of all Fit To Win Medical Staff Credentialing procedures listed in #8 will lead to the receipt of a Fitness Specialist Certificate. (See Fitness Specialist Certificate).
10. Staff credentials will be reviewed annually. Renewal of credentials will be based on weekly quality assurance audits (See Quality Assurance HRA follow-up and performance) and granted in accordance with local policy.

Standing Operating Procedures

Duties of NCOIC

I. Purpose

Provide a list of general duties for the Fit To Win NCOIC.

II. Applicability

Any Fit To Win NCOIC.

III. Responsibilities/Duties

1. The NCOIC will be credentialled/certified to perform all administrative clerk functions as well as all Fitness Specialist duties.

2. The NCOIC will be responsible for the daily operation at the Fit To Win Inprocessing Center or Station.
3. He/she will be responsible for all Fit To Win supply functions.
4. He/she will assist with enlisted and civilian employee training, evaluations, scheduling and payrolls.
5. He/she will be responsible for all daily and monthly quality assurance procedures and credentialling of personnel.
6. He/she is responsible for fire, safety, infection control plans and procedures.
7. He/she will be directly supervised by the Fit To Win Coordinator.
8. He/she will be responsible for other duties as assigned.

Standing Operating Procedures

Duties of Medical Fitness Specialist

I. Purpose

Provide a list of duties for the Fit To Win Medical Fitness Specialist.

II. Applicability

All Fit To Win Medical Fitness Specialists.

III. Responsibilities/Duties

1. The Fit To Win Medical Specialist should be credentialled to perform the following functions:
 - a. Clinical techniques-e.g. blood pressure, height, weight determinations
 - b. Lab techniques-e.g. blood collection, cholesterol, analysis, cholesterol analysis quality control.
 - c. HRA interpretation and lifestyle intervention planning.

Figure E-1. Annex E — Continued.

Standing Operating Procedures

Duties of Administrative Specialists**I. Purpose**

Provide a list of duties for the Fit To Win Administrative Specialists.

II. Applicability

All Fit To Win Specialists.

III. Responsibilities/Duties

1. The Fit To Win Administrative Specialist should be credentialled to perform the following functions:
 - a. Assist in completion of HRA questionnaires.
 - b. Input HRA's into the computer.
 - c. Trouble-shoot basic programming problems.

Standing Operating Procedures

Privacy Act Statement**I. Purpose**

To insure each participant is provided an opportunity to read and sign a Privacy Act Statement.

II. Applicability

All Fit To Win participants and staff.

III. Responsibilities/Duties

1. All Fit To Win participants will be given an opportunity to read and sign a Privacy Act Statement prior to participating in the program.
2. If the participant does not wish to read and sign a Privacy Act Statement, the Health Risk Appraisal form will indicate that the Privacy Act applies.

Figure E-1. Annex E — Continued.

Information Required by the Privacy Act

Sample

a. Authority: 10 USC 3012.

b. Principal Purpose: To provide information regarding personal identification, health history, vital signs, and lab determinations to assist Fit To Win personnel in assessing general and cardiovascular health risk status.

c. Routine Uses: Completed form contains basic information which is used to:

- (1) Identify health risk areas in order to inform and advise the participant.
- (2) To plan and coordinate educational and medical intervention based on the risk assessment.
- (3) To detect specific abnormalities in blood pressure, pulse, serum cholesterol and weight in order that these conditions can be addressed by the health care team.

d. Mandatory Disclosure and Effect on Individual not Providing Information: Providing information on the health risk appraisal is voluntary, but required in order to participate in the Fit To Win Program. Subsequent levels of health interventions are also voluntary.

Date _____ Signature _____

Figure E-1. Annex E — Continued.

Subject: Medical Statement

Sample

Dear Doctor,

1. Your patient_____has expressed a desire to participate in a physical conditioning program.
2. Your client was advised to be seen by you, his/her private physician, to ensure that it is safe for him/her to exercise.
3. We would appreciate your signature on the enclosed form to clear your client. If you have specific exercise recommendations for your client, please indicate them on this form.

Thank you

Fit To Win Coordinator
Ft. Anywhere, USA

Figure E-1. Annex E — Continued.

Physician Statement of Eligibility for Physical Exercise

Sample

Dear Fit To Win Coordinator

This statement certifies that I have evaluated _____ and have found Evidence No Evidence (circle one) to suggest that he/she may be harmed by an exercise program.

1. Exercise Prescription:

Exercise heart rate should be: _____

2. Permitted Activities: (check as appropriate)

- ☐ aerobic calisthenics
- ☐ stationary bicycling
- ☐ swimming
- ☐ running
- ☐ walking
- ☐ weight training

3. Exercise:

Length of time and frequency/week

4. Limitations/Comments:

Physician Signiture

Date

Figure E-1. Annex E — Continued.

Date _____

[illegible]

Sample Form

Figure E-1. Annex E — Continued.

Sample**Instructions**

The following exam includes 30 matching, multiple choice, true/false and short answer questions. Select the best answer for each question.

You have one hour to complete the exam.

1. What are the primary goals and philosophy of the Fit To Win Health Promotion Program?
 - a. To recruit enough clients to ensure the continuation of the program.
 - b. To discuss enough content to initiate a process of change.
 - c. To assist the client in changing his or her negative health habits.
 - d. Provide the client with a positive escape from his/her worries.
2. The following are the steps in Fit-To-Win Health Promotion Program. (Please number them in the correct sequence.)

___ Identify actual or potential health risks	___ Recommend lifestyle change
___ Develop plan	___ Gather data
___ Analyze HRA data	___ Follow-up (long term)
- 3-12. Match one letter with one number as appropriate:

___ 3. Hypertension	a. At least 3 times per week, brisk, nonstop, 20-30 mins
___ 4. Bacon, liver, chicken skin, egg	b. Tars, cyanide, carbon monoxide
___ 5. Diabetes	c. Pressure in arteries as heart contracts
___ 6. Aerobic exercise	d. Same as high blood pressure
___ 7. Stress management	e. Recommend no more than one source or serving ingested per day
___ 8. Cigarette-tobacco chemicals	f. Primary risk factors include obesity and family history
___ 9. Caffeine	g. Pressure in arteries as heart relaxes
___ 10. Systolic blood pressure	h. May involve techniques such as relaxation, deep breathing
___ 11. Diastolic blood pressure	i. Rich sources of cholesterol and saturated fat
___ 12. Alcohol	j. Coffee, tea, chocolate
13. Name one type of food which is important in preventing osteoporosis (brittle bone disease)
_____.
14. The current recommended goal for blood cholesterol level is less than _____mg/dl.
15. A person is considered to have hypertension if consecutive measurements reveal a blood pressure greater than _____/_____mmHg.

Figure E-1. Annex E — Continued.

Sample

16. List three risk factors for hypertension:
a. _____ b. _____ c. _____
17. When a participant in the Fit-To-Win Program is identified as a smoker, the outbriefer should:
a. Demand that he stop. c. Advise him to stop, provide rationale, offer smoking cessation assistance.
b. Immediately enroll him in smoking cessation program. d. None of the above.
18. List three risk factors for heart attack:
(1) _____ (2) _____ (3) _____
19. List three warning signs of an impending heart attack:
(1) _____ (2) _____ (3) _____
20. The following are goals of the Fit-To-Win Program *except*:
a. Reduced absenteeism
b. Reduced doctor visits
c. Increased disciplinary action by unit commanders to enforce participant lifestyle changes
d. Improved morale.
21. Monitoring training heart rates or using the "talk test" can assist a participant in exercising at a safe and adequate intensity. These techniques apply to _____ types of exercise.
22. Self testicular exams for men and self breast exams for women should be done at least:
a. Daily b. Weekly c. Monthly d. Yearly
23. When dispensing blood from a capillary tube for cholesterol analysis, a small blood clot in the tube is not important and will not effect the test results.
a. True b. False

The following questions present a series of situations which might be encountered during the HRA outbrief. Read each one and write a short description of the appropriate intervention recommendations.

24. A 24 year old active duty male has had a long history of knee pain after running, and has not been able to train adequately. Consequently, he has not passed the last PT test.
Your intervention recommendations include:
25. You are outbriefing a 50 year old male participant who is a civilian employee. He wishes to begin physical conditioning but has never exercised.
Your intervention recommendations include:

Figure E-1. Annex E — Continued.

Sample

26. You are outbriefing a 35 year old female whose HRA indicates that she had not had a PAP test in 2 years and does not do regular breast self-exam.
Your intervention recommendations include:
27. A 38 year old male participant is found to have a blood pressure of 150/96. He has no history of high blood pressure. He also has a cholesterol of 250 mg/dl.
Your intervention recommendations include: (state which problem has highest priority)
28. A 35 year old male is overweight with a history of not having exercised for several years. He is very interested in starting an exercise program. What is the first step you would advise him to take?
29. A 40 year old female who is in fair condition has been running for 4 weeks. She wants to know how hard to run. She has been cleared by her medical doctor for any exercise activity.
Describe what you would tell this person in terms of target heart rate and appropriate intensity of workout.
30. A person age 39 who is mildly hypertensive and overweight has been cleared for exercise programs by a medical doctor. This individual is under the impression that he can lose the excess weight by eating less and sitting in a sauna or steam bath.
What advice would you give him?
31. Principles of infection control at the Fit-To-Win station include all the following *except*:
- a. Strict handwashing technique utilized between each participant contact during blood drawing.
 - b. Cleaning of auto click finger puncture device with alcohol after each use.
 - c. Reuse of capillary tubes for blood collection.
 - d. Use of strict aseptic technique during blood drawing.
32. When providing participants with instructions for weight control, which of the following suggestions should *not* be offered.
- a. Fast at breakfast and lunch to decrease calorie intake
 - b. Eat low calorie foods such as fruits and vegetables.
 - c. Do not keep high calorie junk food available at home.
 - d. Eat three well balanced meals per day.
 - e. Take diuretics (water pills) to get the weight loss process started.
 - f. Exercise regularly, three times/week.
- (a) b,c (b) c,d (c) a,e (d) a,b
33. List three physical stress signals:
- (1) (2) (3)

Figure E-1. Annex E — Continued.

Answer Key Certification Exam

- | | |
|--|----------------------------------|
| 1. C | 7. H |
| 2. 3 identify actual or potential health risks | 8. B |
| 4 develop plan | 9. J |
| 2 analyze HRA data | 10. C |
| 5 recommend lifestyle changes | 11. G |
| 1 gather data | 12. E |
| 6 follow-up | 13. Dairy products, high calcium |
| 3. D | 14. 200 |
| 4. I | 15. 140/90 |
| 5. F | |
| 6. A | |
-
16. Students must have three of the following:
Family history, Spiking of blood pressure in youth, Obesity, High salt intake, Smoking, Stress, High cholesterol, Diabetes, Increased age, Male or Black people.
17. C
18. Students must have three of the following:
Age (over 40), Heredity, Weight, Tobacco smoking, Exercise, Cholesterol, Blood Pressure, Male, Abnormal electrocardiogram, Diabetic, Increased stress or tension
19. Student must have three of the following:
Uncomfortable fullness, pressure, or squeezing in center of chest, Pain may spread to shoulders, neck, or arms, Dizziness, Sweating, Nausea, Shortness of breath, Sense of Impending doom
20. C
21. Aerobic
22. C
23. B
24. Review importance of: Proper running shoes; running on varied surfaces hardtop, grass, give written material; Physical Therapy consult.
25. Discuss principles of exercise, elements of an aerobic work out; give written material, give participant referral to civilian; doctor for exercise clearance

Figure E-1. Annex E — Continued.

26. Advise participant of role of PAP test and self breast exam in early detection of cancer; provide "HOW TO" literature on self breast exam; give consult to GYN service.
27. Priority #1: Give participant consult for 3 days BP check to MTF or private Doctor. Give participant literature and information on hypertension advise participant on normal range for BP.
Priority #2: Advise participant on normal range for cholesterol. Give participant information on unit level classes. Give participant written literature and referral to MTF or his private health care provider
28. Evaluation by his medical doctor
29. First teach pulse taking (radial or carotid pulse); then teach formula for target heart rate (225-age-resting pulse X intensity (in this case 65%-70%) + resting pulse = target heart rate; finally, teach the person how to run a few minutes, take pulse, compare exercise heart rate to target heart rate and adjust if necessary. Also, teach how to progress to higher target heart rate by using 75% or 80% intensity in the formula.
30. Weight can be reduced by reducing caloric intake but fat will not be reduced by dieting alone. Aerobic exercise must be used to lower fat. Steam baths, saunas, wet suits, etc. are not effective in controlling body fat content.
31. C
32. C
33. Any three of the following:
Sudden weight gain (or loss), Gastro-intestinal difficulties, Neck pain, Back pains, Fatigue, Trembling or shaking, Nausea, Stomach pains, Skin irritations, Stuttering, Diarrhea, High blood pressure, Headaches, Teeth grinding, Increased perspiration, Cold hands or feet.

Annex E (Continued)

Sample Daily Maintenance Log						Serial Number							
Date													
Reflotron Calibration													
Cleaning													
Dust Filter													
Pipetter													
Fan													
Petrie Dish													
Autoclax													
Optics Panel													
Operator Initials													
Verified By													

Figure E-1. Annex E — Continued.

Reflotron® Quality Control Log

BOEHRINGER
MANNHEIM
DIAGNOSTICS



Test Name	Test Lot No.	Units (i.e. mg/dL)	Mean Acceptable Range	Control Name	Control Lot No.	Control Exp. Date
CHOLESTEROL	23405431	mg/dL	205 (174-236)	PRECINORM	158096	
Date	10/19/87	17/24/87	22/24/87	25/26/87	27/28/87	29/30/87
Result	211	181	173	203	195	201
Upper Limit						
Mean						
Lower Limit						

Test Name	Test Lot No.	Units (i.e. mg/dL)	Mean Acceptable Range	Control Name	Control Lot No.	Control Exp. Date
CHOLESTEROL	23405431	mg/dL	210 (178-242)	PRECIPATH	158019	
Date	10/19/87	17/24/87	22/24/87	25/26/87	27/28/87	29/30/87
Result	190	190	188	204	205	199
Upper Limit						
Mean						
Lower Limit						

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3 503 0885

Test Name	Test Lot No.	Units (i.e. mg/dL)	Mean Acceptable Range	Control Name	Control Lot No.	Control Exp. Date
Date						
Result						
Upper Limit						
Mean						
Lower Limit						

Test Name	Test Lot No.	Units (i.e. mg/dL)	Mean Acceptable Range	Control Name	Control Lot No.	Control Exp. Date
Date						
Result						
Upper Limit						
Mean						
Lower Limit						

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3 503 0885

Sample Completed Form

Figure E-1. Annex E — Continued.

E-2. Title Not Used.

Paragraph not used.

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